Washington State Department of Social & Health Services

CORE AGREEMENT REQUEST

REQUESTED BY:	PROVIDER TYPE:	DATE REQUESTED:

Mailing Address

ATTENTION: _____

_____

Telephone: 753-4711

Provider Enrollment
Office of Provider
Services
MS 5562

Type of License

- ☐ Professional
- ☐ RN and ARNP
- ☐ Medicare Certification
- ☐ Home Care Agency License
- ☐ Business
- ☐ ASHA Certificate
- ☐ Graduation of Psychiatry Resident Program Certificate

Type of Form

- ☐ Core Agreement
- ☐ Midwife Letter
- ☐ Dental Hygienist Letter
- ☐ Home Care Agency License Questionnaire
- ☐ Appendix A
- ☐ DME Letter
- ☐ Electronic Billing Agreement
- ☐ Other (Specify) _____
- ☐ Power of Attorney
- ☐ Modified Unit Dose
- ☐ Disclosure Statement

Highlight The Following Areas

- ☐ Non-Discrimination Clause
- ☐ Section I
- ☐ Section II
- ☐ Section III
- ☐ Does Not Apply

SENT BY:	DATE:

DSHS 16-153 (03/1992)